EXHIBIT A

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

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MARK SNOOKAL, an individual, Plaintiff, vs. CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive, Defendants.	)	Case No. 2:23-cv-6302-HDV-AJR

DEPOSITION OF

DR. VICTOR ADEYEYE

Volume 1, Pages 1 - 34

Taken Remotely Via Videoconference

Friday, November 15, 2024

Stenographically reported by:
Renee M. Bencich, CSR No. 11946, RPR

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Chevron Nigeria Limited

Mark Snookal, the plaintiff in this case?

A. No notes.

Q. Okay. Okay. Who is your current employer?

A. Chevron Nigeria Limited as a contractor.

Q. Okay. How long have you worked for Chevron Nigeria Limited?

A. Seven years plus.

Q. Okay. What's your current job title?

THE COURT REPORTER: I'm sorry. One more time, Doctor. The first word I did not understand.

THE WITNESS: Seven years -- May twenty -- May 2017 to date. Seven years.

MS. FLECHSIG: I think he said consultant cardiologist --

THE WITNESS: May --

BY MS. FLECHSIG:

Q. -- am I correct?

A. May -- yes. May 2017 to date as consultant physician cardiologist.

Q. Okay. So you've been a consultant physician cardiologist since May of 2017, correct?

A. For Chevron.

Q. For Chevron.

Okay. Before becoming a consultant physician cardiologist, what position for Chevron did you hold?

Or that's when you started?

A. Again, please.

Q. Sorry. So you started -- your first job for Chevron Nigeria Limited was consultant physician cardiologist?

A. Yes.

Q. Okay. And before May of 2017 you were working for a different company?

A. I was in a university as a consultant cardiologist and lecturer.

Q. Understood.

Okay. As a consultant physician cardiologist, what are your job duties?

A. Job duties include acute emergency management for cardiovascular cases and other medical emergencies in --

THE COURT REPORTER: May I ask the witness to repeat?

MS. FLECHSIG: (Counsel nods head.)

THE COURT REPORTER: Doctor, if you'd please repeat your answer.

THE WITNESS: Job description, management of acute medical emergency and outpatient management of medical cases, especially cardiovascular disease.

THE COURT REPORTER: Thank you.

One more time. I didn't understand one word.

THE WITNESS: Okay. The very case I mentioned, it was dissecting eventual rupture and patient passed away. The very case. In the last 10, 12 years. Thank you. Before Chevron.

BY MS. FLECHSIG:

Q. Okay. I know you've said that there was an autopsy conducted, so I --

A. Yes.

Q. -- want to clarify.

A. Yes.

Q. That was after you treated the patient, or were you conducting -- you were conducting the autopsy?

A. When we conducted the autopsy. It was a follow-up patient. Nothing could be done. Ruptured, and that was the --

THE COURT REPORTER: And -- I'm sorry. May we go off the record real quick?

MS. FLECHSIG: Yes.

THE COURT REPORTER: Thank you.

(Off the record.)

(The record was read as follows:

QUESTION: That was after you treated the patient, or were you conducting the autopsy?)

ANSWER: When we conducted the autopsy. It was

a follow-up patient. Nothing could be done. Ruptured, and that was the --)

THE COURT REPORTER: There was more.

THE WITNESS: Mortality. Death. Death.

THE COURT REPORTER: Thank you.

BY MS. FLECHSIG:

Q. So was the patient alive when they first came to you?

A. Yes.

Q. Understood.

Were you able to administer any treatments to the patient before they passed away?

A. The treatment could not be given. Not available.

Q. Understood.

Do you have a current curriculum vitae or a resume?

A. Have but not updated.

Q. Okay. Do you know when you would have last updated it?

A. Over a year ago.

Q. Have you published any medical research during the last 10 years?

A. Two contributions to textbooks of medicine with over 20 publications in local and international

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

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MARK SNOOKAL, an individual, Plaintiff, vs. CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive, Defendants.

Case No. 2:23-cv-6302-HDV-AJR

REPORTER'S CERTIFICATION
ORAL DEPOSITION OF
DR. VICTOR ADEYEYE
Volume 1, Pages 1 - 34
Friday, November 15, 2024

I, RENÉE M. BENCICH, Certified Shorthand Reporter in and for the State of California, hereby certify to the following:

That the witness, DR. VICTOR ADEYEYE, was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

I further certify that pursuant to FRCP Rule 30(e)(1) that the signature of the deponent:

(XX) was requested by the deponent or a party before the completion of the deposition and returned within 30 days from date of receipt of the transcript. If returned, the attached Changes and Signature Page contains any changes and the reasons therefor;

( ) was not requested by the deponent or a party before the completion of the deposition.

I further certify that I am neither attorney nor counsel for, related to, nor employed by any of the parties to the action in which this testimony was taken.

Further, I am not a relative or employee of any attorney of record in this cause, nor do I have a financial interest in the action.

Subscribed and sworn to on this the 1st day of December, 2024.

Renée M. Bencich

RENÉE M. BENCICH, CSR, RPR
California License No. 11946

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

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MARK SNOOKAL, an individual, Plaintiff, vs. CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive, Defendants.	Case No. 2:23-cv-6302-HDV-AJR

REPORTER'S TRANSCRIPT

VIDEOTAPED DEPOSITION OF

DR. VICTOR ADEYEYE

VOLUME 2

Tuesday, April 22, 2025

Via Zoom Video Conferencing

6:00 a.m.

Reported by: Rachel N. Barkume, CSR, RMR, CRR
Certificate No. 13657

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THE VIDEOGRAPHER:

Cliff Gonshery

ALSO PRESENT:

Eguono Erhun, Chevron Nigeria Limited

why maybe, maybe not. Alleviating the symptoms medically does not equate to addressing the dissection, the tearing. That's what I mean by that.

BY MS. FLECHSIG:

Q. What can you do to alleviate the symptoms of the dissection?

A. Give some peripheral beta blockers.

Q. And what does that do for someone?

A. What's that?

Q. Yeah. What does that do for someone who's had a dissection?

A. That would reduce the symptoms of pain, excruciating pain, that individual would be having.

Q. Okay. Does it -- does it slow their risk of death from occurring while they await surgery?

Or does it have any other benefits?

A. No. No. It confers no benefit of survival on such individual.

Q. Understood. Okay.

Have you ever treated a patient whose dilated aortic root has dissected?

A. None of note.

Q. Okay. Sorry, you said "none of note."

There's -- there's none that you have treated?

A. No. No. None.

Q. Okay. Have you ever treated someone with a dilated aortic root that ruptured?

A. No.

Q. Okay. Okay. I want to ask about Mark Snookal, the plaintiff in this lawsuit.

Have you reviewed the complaint in this lawsuit?

A. How?

Q. Just -- yeah, have you reviewed the actual complaint of the lawsuit, so at any time --

A. I'm not -- I'm not privy to that document.

Q. Okay. When did you first hear the name Mark Snookal?

A. 2019.

Q. Okay. And how did you -- how did you hear about him?

A. Via e-mail communication between myself and the occupational health unit; Dr. Femi Pitan, you mentioned, Dr. Asekomeh, Dr. Henry Aiwuyo.

Q. I'm sorry. Who was the third one that you said?

A. Via e-mail communication --

Q. Oh --

A. -- with myself and the occupational health

Q. So we're at the top of Exhibit A now.

A. Yes, that's my response. That's the summary of my own search.

Q. Okay. So there's this August 5th, 2019, e-mail, and this is your summary of your research; correct?

A. Yeah. Yeah. Yes.

Q. Okay. There's -- is there anything that you know today that would change your opinion of what you expressed in that August 5th, 2019, e-mail?

A. I don't get your question, please. Again, please. Repeat again, please.

Q. Oh, I'm sorry. I think my internet -- apologies. Yeah.

I just was asking is the opinion you expressed in this August 5th, 2019, e-mail -- is that consistent still with your opinion today of Mark Snookal's cardiac condition?

A. Very consistent. Very consistent.

Q. Okay. So you said that you undertook some research to inform this opinion.

What did you do to find -- what did you do to research?

A. First of all, I search for such cases in Nigeria, and that brought me to a publication I was part

of the author; 2,501 echocardiographic studies for individuals with heart conditions. I mean 2,501 cardiac patients, what did we find out is their cardiac condition. Why is that so? That is so, for me, to have an idea how many of such cases do we see in real life.

And I found out that it's quite very rare. This publication, which I'm part of the author, is available -- can be made available to you. Out of 2,501, no such case, and that tells you the reality of the condition, the limited cases of such condition to warrant physicians' experience.

Then I also found out that most of those cases were from autopsy, not in real life. I look at literature and I saw that, oh, even for those cases being found, they were found at autopsy. Those are local cases. And I also look at a U.S. study between 1999 and 2016, then; the epidemiology of fatal ruptured aortic aneurysms in the United States. Epidemiology of fatal ruptured aortic aneurysms in the United States, 1999 to 2016.

This also gives me an idea how much of mortality is still with this condition. So putting all these things together, I was able to have my own opinion; which, looking at literature from 2019 to now, they say the same; and I am able to advise, as put in

this, my write-up, on such cases. Thank you.

Q. Okay. Thank you for that. I just wanted to clarify.

How many -- how many studies did you review? It sounds like there were two. Or am I missing some?

A. Okay. Two local studies. I can remember one now. And one foreign study. The foreign study is the one in United States, 1999 to 2016, epidemiology of fatal ruptured aortic aneurysms in United States, 1999 to 2016. The local one I remember vividly was an article I also am part of the co-authors, the 2,501 cases echocardiographic studies done in the Southwestern Nigeria. This can be made available to you if you are so interested, or you can go online and search there. Thank you.

Q. Okay. So the local study using 2,051 echocardiographic studies --

A. 2,501. '501.

Q. 2,501?

A. '01. '501, yes.

Q. Sorry. Okay. 2,501 local studies.

You said it's reviewing that number of echocardiographic studies; correct?

A. Yes.

Q. But it's not specifically on people with

dilated aortic roots; it's just echocardiographic studies generally; correct?

A. Yes. That's a sample study showing us that that condition is rare. If you do echo on 2,501 individual and cannot have one case, that tells you it's quite rare. And the available local studies of such cases are at postmortem, autopsy, and that gives a lot of clinical information. Thank you.

Q. Understood.

(Reporter clarification.)

BY MS. FLECHSIG:

Q. The postmortem studies, is -- strike that.

So you said of the 2,501 echocardiographic studies done locally, none of those showed patients with a dilated aortic root; correct?

A. Correct. Correct.

Q. Okay. Is it fair to say that dilated aortic roots are more rare in Nigeria than in the United States?

A. You cannot say that because we've not actually compare region to region. What we can say is most cases are found at autopsy.

Q. Understood.

A. Because patients don't often live to warrant such evaluation for treatment and what have you. I

don't know if I'm getting my point. So it takes high index of suspicion and a standard screening methods for you to dictate. But any country where autopsy is top notch, you can see more of such.

Q. Understood. Did any of the studies you referred to refer to a patient's risk of mortality when they do have a dilated aortic root?

A. Mortality is over 90 percent.

Q. So -- okay. So let me clarify.

You referred to -- the studies referred to someone with a dilated aortic root having a 90 percent risk of mortality?

A. Over 90 percent risk of mortality.

Q. Is that a risk of mortality once they have suffered a dissection or rupture?

A. That is once they have suffered a dissection or rupture.

Q. Okay.

A. The mortality --

Q. I am so sorry. Go ahead.

A. In other words, when they suffer a dissection or rupture; the chance, the likelihood of that is over 90 percent.

Q. Understood. Which of the studies that you cited referred to that statistic?

A. Some of the local studies revealed before my submission.

Q. Okay. Did any of the studies you referred to discuss the overall risk of a rupture or dissection occurring when someone has a dilated aortic root?

A. The risk of rupture or dissection is done based on those centers, those regions that were able to pool patient with aortic dilatation, and they were able to put some theory to measure the risk. Like I told you, in our setting, it is not a common occurrence.

If I are to do 2,501 echocardiography, and I cannot find one, so how many will I do to have a sizable number to apportion risk? I don't know if I'm clear on that.

Q. Yeah, I think so. What I'm trying to understand is, I guess, did you refer to anything that gave you a sense of how often someone with a dilated aortic root has a rupture or a dissection?

A. Yes. Yes. Some of them in that e-mail link, if you click on them and read, you will see the Western literatures studying the risk of dissection, the risk of rupture, and the attendant mortality related.

Q. In the -- you're referring to the University of Calgary article that Dr. Aiwuyo linked to?

A. Those links.

descriptions of the individual. How do I mean? If somebody has frequent arrhythmias from palpitations and what have you, and they ask me, what is your opinion on this? I can say, oh, this person stands a risk of disturbing arrhythmia with chest pain, with difficulty with breathing. And based on this, there are various aids, put them on this kind of drug, to be seen with this frequency, once a month, once in two weeks, once in three months, once in six months.

They are the one who understand the works they do. Oh, this one is going to climb crane. This one is going to be in the air. This one is going to be in the boat. This one is going to be on the sea. And they will now be able -- being doctors, too -- to match the opinion of an expat with the work of the very individual. Thank you.

Q. So what kind of information do you consider when you're assessing the risk of an individual's cardiovascular condition?

A. The information I consider are patient orient on point results -- cardiovascular results. And there are three or four main results that are important to consider their cardiovascular -- for their cardiovascular status, either their ECG, their echo, or other imagings.

These are the things that are necessary to put things together and make an opinion. Because most cardiovascular opinions are based on data from very specific cardiac values, cardiac results, not based on is he genotype, is he BMI, is he dark or white or blue or black. No. Thank you.

Q. Aside from your own medical expertise, are there guidelines you're required to follow when assessing the risk of an individual's cardiovascular condition?

A. Yes. There are guidelines.

Q. What kind of --

A. Guidelines that are developed by reputable institution, for example, Nigeria -- potentially Society of Nigeria -- Nigerian Cardiac Society. These bodies develop guidelines that help us to make informed decision.

Also on international scale, there are European Society of Cardiology, American College of Cardiology, Canadian College, and they all have guidelines available for us. And these are the things that we look into at the time we have to make decisions, and these are available to everyone on websites, on subscriptions, in journals, and at our conferences. We look at all these guidelines, merit, demerit, what have you, and

deliberate. Thank you.

Q. And when you're making your assessment of risk relating to an individual's cardiovascular condition, is any part of your compensation based on the conclusions you reach in your assessments?

A. Compensation how? I don't get.

Q. Your -- your pay. Your salary compensation.

Is any of that based on the conclusions that you reach in your assessments of risk?

A. We've not gotten to that. That's not part of -- the salary structure -- of the medical, no. We are not paid by the opinion you make, the recommendation you make, and all that. No. No. No. That has no bearing, any payslip or any payment structure. It's just an advisory.

And for your information, please, it's like a lawyer who has a case and he knows of a colleague who has and do such case and just share opinion, what's your advice on this? Which, of course, the person goes into the archive or the legal literature and give opinion on that. That is not with remunerations because, like I said, this is teamwork. It is part of what I'm supposed -- when they ask for my opinion on such cases about a impression I had, I give.

Same way a surgeon who want to fix bone from

For an individual with an aortic dilatation, is the occurrence of a dissection or a rupture predictable?

MS. FLECHSIG: Objection. Incomplete hypothetical.

THE WITNESS: Science give us guidelines on monitoring of such patient and give us opportunity to make some prediction, and that's why we're able to classify the risk for any individual with aortic dilatation. The risk of dilatation -- the risk of dissection, I mean, the risk of rupture is this, this, this, this, based on these diameter, this dimension. That's what science tells us. Thank you.

BY MS. FAN:

Q. Did you speak with Mr. Snookal in making your assessment of his risk relating to his cardiovascular condition?

A. No. No. I didn't do medical consultation with Mr. Snookal. No medical consultation with Mr. Snookal. I've said it over and over.

Q. And in your assessment of Mr. Snookal's risk relating to his cardiovascular condition, did your assessment of risk require a conversation with Mr. Snookal?

A. Not at all. Not at all. Not at all.

Q. Why was -- why wasn't it necessary to speak

with Mr. Snookal regarding his condition in order to assess the risk of his condition?

A. The beauty of medical science is ability to prognosticate based on available evidence. In Mr. Snookal's case, all is required for any cardiologist all over the world to put him into any risk is for that cardiologist to have an idea of the dimension of his dilatation.

Any cardiologist anywhere in the world will give you a risk value without seeing Mr. Snookal. Just like the other case I mentioned, any individual with cardiac failure with ejection fraction, EF, 30 or 40 percent has likelihood of being dead 50 percent within six month to one year. This what science has gone for, over the decades, in cardiology. So I don't need to speak to Mr. Snookal to make that assertion of the risk level. Thank you.

Q. And did you speak with Mr. Snookal's cardiologist in making your assessment of his risk relating to his condition?

A. The answer is no.

Q. And in your --

A. Because -- say what?

Q. I didn't mean to cut you off. Go ahead, Doctor.

A. I do not need to have that conversation with Mr. Snookal's cardiologist. Please note and please note, Mr. Snookal and his cardiologist are relating with doctor in occupational health, not with me as a cardiologist. So there is no room for that.

And I use the word "blinded opinion," without bias. An opinion is blinded to remove elements of bias, elements of conflicts of interests. That is why it has to be blinded. And that is why some parameters like the liver function test, E/U/Creatinine and others, were not privy -- were not made available to me because I do not stand in that occupational health department to understand all the protocol and do their risk assessments for patients' suitability to work called fitness for duty. Thank you.

Q. In other words, you were making an independent assessment of risk --

A. Excellent.

Q. -- regarding --

A. Excellent.

Q. -- the cardiological --

A. Excellent.

Q. -- condition.

A. Excellent. That is summary. Thank you.

Q. And you also testified earlier that you didn't

just the third buckets; and that very third bucket, just a small part of it is cardiac. The renal function is there, the liver function is there, the brain function is there, the metabolic is there. It's just that cardiac. That is required of me to make an opinion.

It is there in occupational health who has everything in these three buckets to make their own informed decision on fitness for duty. Thank you.

Q. And these other types of inform- -- medical information regarding Mr. Snookal that is being considered by occupational health but which was not available to you -- all of that other information, like you said, was not necessary to your assessment of his cardiological risk; is that right?

A. Yeah.

MS. FLECHSIG: Objection as to form, including assumes facts not in evidence.

THE WITNESS: Okay.

BY MS. FAN:

Q. And if you had additional information regarding Mr. Snookal's family history and their medical conditions, would that have --

A. Excellent.

Q. -- would that have impacted your assessment --

A. Excellent question.

Q. -- of Mr. Snookal's risk --
A. Excellent question.
Q. -- of --
A. Excellent question. Excellent question. It's --
MS. FLECHSIG: I'm sorry, form objection. Incomplete hypothetical.
THE WITNESS: Yes. Yes. Yes. It's hypothetical. But there is a science to this hypothesis. And the science to this is -- the medical science of this is an individual who has aortic root dilatation of 4.2, 4.5 centimeter with a positive family history of Marfan syndrome, Ehlers-Danlos syndrome, this individual is a chronic smoker, this person has coronary heart disease, this individual has to do heavy lifting of objects, that could have worsened -- emphasis "worsened" -- this risk assessment.
That could have worsened the submission of the risk -- will have increased, will have been worsened if all these are present in that individual. I can only get all of these when you do a full medical consultation: The family tree, the metabolic panel, and his social history. These could have worsened the risk because history of all of those, smoking, positive family history, connective tissue disorder, like I

mentioned, the Marfan, the Ehlers-Danlos -- all of them worsen the aortic dilatation, because the risk of dissection or ruptures multiplies in multiple folds if any of these are present. Thank you.

BY MS. FAN:

Q. Understood. So to understand -- to make sure I understand that correctly, if you had additional information, aside from the -- aside from the imaging reports, it would have -- it would have indicated a higher level of risk for Mr. Snookal; is that correct?

A. Yes. And I mentioned those factors that could have increased the level of risk if they are there. I mentioned, like, five. If they are there, the level of risk will have increased if they are positive from medical consultation.

THE REPORTER: Counsel, are we at a good break spot?

MS. FAN: Yes. We can take a quick break here. What are we thinking, five or ten minutes?

THE REPORTER: I think it's been an hour, so if we could do ten.

MS. FAN: Okay.

THE VIDEOGRAPHER: Off the record. Time now, 8:43 a.m.

(Off the record.)

cases in Escravos, and no full complements of medical specialists in Escravos. Thank you.

Q. That means there's no cardiologist on site in Escravos; is that right?

A. There is no designated cardiologist, no designated surgeon, no designated anesthetist in Escravos.

Q. Earlier you mentioned that if an individual experiences a dissection, they require immediate intervention within a couple of minutes.

A. Yes.

Q. Are those interventions available in Escravos?

A. No. No. No, even in Warri, not available, not talk of Escravos.

Q. Then you mentioned interventions for a rupture. Are those available in Escravos?

A. No. No. No. No.

Q. And so based on what you know of Mr. Snookal's cardiovascular condition and the medical resources available in Escravos, if Mr. Snookal had experienced a cardiovascular complication in Escravos, would it have led to his death?

MS. FLECHSIG: Objection as to form.

THE WITNESS: Hypothetical, if I may say, but it could have led to his death. Why? Because both the

medical personnel -- medical facility, medical personnel required, both in Escravos and in Warri location, are not there.

MS. FAN: Understood. Thank you. I don't have any further questions at this point.

MS. FLECHSIG: I just have a couple of follow-up. It will be -- I think it will be very quick. If I may.

EXAMINATION

BY MS. FLECHSIG:

Q. So, Dr. Adeyeye, you testified about, sort of, a golden period during which someone who has suffered a dissection or rupture has the best odds of survival through medical intervention; is that correct?

A. Yes.

Q. Okay. And you said that someone generally needs to get care within minutes if they suffer a rupture; correct?

A. Yes. Yes.

Q. And that's true no matter where the person's rupture occurs. In other words, if they're in the United States, they need to get care within minutes. If they're in Escravos --

A. Yes.

Q. -- they need to get care within minutes.

CERTIFICATE OF STENOGRAPHIC REPORTER

I, RACHEL N. BARKUME, a Certified Shorthand Reporter of the State of California, hereby certify that the witness in the foregoing deposition,

DR. VICTOR ADEYEYE,

was by me duly sworn to tell the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein named; that the testimony of said witness was stenographically reported by me, a disinterested person, and was thereafter transcribed into typewriting.

Pursuant to Federal Rule 30(e), transcript review was requested.

I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said caption.

DATED: May 6, 2025.

Rachel N. Barkume

Rachel N. Barkume, CSR No. 13657, RMR, CRR

EXHIBIT B

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

MARK SNOOKAL, an individual,

Plaintiff,

vs.

CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive,

Defendants.

Case No.

2:23-cv-6302-HDV-AJR

DEPOSITION OF DR. UJOMOTI AKINTUNDE,

commencing on Thursday, October 31, 2024, at 8:00 a.m., Pacific Time, held via Zoom videoconference, all participants appearing remotely before Lauren Ramseyer, Certified Shorthand Reporter, CSR No. 14004.

I N D E X

WITNESS:

DR. UJOMOTI AKINTUNDE

APPEARANCES:

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ALLRED, MAROKO & GOLDBERG

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ALSO PRESENT: EGUONO ERHUN

ago.

Q. As you sit here today, though, you don't have any memory of discussing it with Dr. Asekomeh other than in this email?

A. Correct.

Q. Okay. Other than Dr. Asekomeh, do you remember speaking about Mr. Snookal and his medical condition with anyone else, other than your lawyers?

A. Dr. Adeyeye, the other cardiologist.

Q. Is Dr. Adeyeye your colleague in Lagos?

A. He works in Chevron Warri, Warri Hospital.

Q. Okay. When did you discuss Mr. Snookal with Dr. Adeyeye?

A. Within the last couple of weeks. Recently, within the last two to three weeks or so.

Q. Okay. Was that one conversation that you had with Dr. Adeyeye about Mr. Snookal?

MS. FAN: I apologize, Counsel. You broke up for me. Would you mind repeating your question?

BY MS. FLECHSIG:

Q. Yeah. How many conversations did you have with Dr. Adeyeye about Mr. Snookal?

A. One or two maximum.

Q. What did you discuss during those conversations?

to ask you some questions about that.

So why did you feel you would be more comfortable if he was on a beta blocker?

A. A beta blocker will slow down the rate of the increase in size of his dilated aortic root. It will slow down the rate of increase, and essentially make him safer, so that was my primary priority, that the patient is safer.

Q. Why does it matter the rate of growth of the dilated aortic root?

A. The rate of growth correlates positively with the rate of dissection and rupture.

Q. In other words, the faster it's growing, the more likely it is to dissect or rupture?

A. Correct.

Q. If a dilated aortic root is stable in size over time, does that, therefore, indicate that the rate of dissection or rupture is decreased?

MS. FAN: Objection. Argumentative.

THE WITNESS: Can you say that again, please?

BY MS. FLECHSIG:

Q. Yeah. So in other words, if the size of the aortic root dilation is stable over time, that would indicate a negative risk factor; there would be less risk that it will dissect or rupture?

MS. FAN: Objection. Argumentative.

THE WITNESS: Well, size is important, so the risk is lower that it would dissect or rupture, but it may also -- that may also occur, even at the current size; that is why there is a risk category to it. So you really want to make sure, like I said, as a physician, my priority one is the health and wellbeing of every patient, so I also want to make sure all the factors that may potentially increase the risk of this person are doing well, are put into perspective and addressed.

BY MS. FLECHSIG:

Q. In your email did you intend to express any opinion about whether it was safe for Mr. Snookal to work in Escravos?

A. That's not within my sphere of work. My communication was strictly cardiology, about the signs, and its possible issues that may arise. Nothing within my sphere of work allows me to determine suitability for work or otherwise.

Q. For someone with an aortic root of 4.2 centimeters, is that a situation where you would recommend surgical intervention?

A. I would not recommend surgical intervention at that size except he didn't have symptoms.

foundation. Vague and ambiguous.

THE WITNESS: It would be higher than the person who does not have a dilated aortic root and is otherwise well, yes.

BY MS. FAN:

Q. So you assessed Mr. Snookal's risk of complication with his dilated aortic root to be low. What did you base your assessment on?

A. The outcomes of people from -- from many -- I mean, experience on literature, the outcome of people in that category, based on scientific literature.

Q. When you say outcomes, what are you referring to?

A. Adverse outcomes, adverse aortic outcomes and death.

Q. I see. So when you say you based it on your knowledge of medical literature regarding his condition, what medical literature are you referring to?

A. I read a lot of articles and medical materials, various kinds, you know, in my -- in the course of my practice. I come across different reading materials or texts.

Q. At the time that you made your assessment of Mr. Snookal's risk of complication, were you aware that his cardiologist had quoted his risk of complication at

Q. Okay. You mentioned you based your assessment of Mr. Snookal's risk of complication on your knowledge of medical literature and his imaging reports. Did you speak --

A. Yes.

Q. -- with Mr. Snookal -- I apologize.

Did you speak with Mr. Snookal in making your assessment?

MS. FLECHSIG: Asked and answered.

THE WITNESS: No.

BY MS. FAN:

Q. And in your opinion, did your assessment of Mr. Snookal's risk require a conversation with Mr. Snookal?

A. No.

Q. Why not?

A. The aortic size is a very strong predictor of outcomes, and I was already given the aortic size.

Q. Okay. Earlier -- strike that.

Have you ever treated a rupture resulting from a dilated aortic root?

MS. FLECHSIG: Asked and answered.

THE WITNESS: No.

BY MS. FAN:

Q. And have you ever treated --

could you state it again, please?

BY MS. FAN:

Q. Yeah, of course. If Mr. Snookal experienced a cardiovascular complication relating to his aortic root, what interventions are required?

MS. FLECHSIG: Same objections, but also incomplete hypothetical. Go ahead.

THE WITNESS: So he would need to be medevaced immediately to the center where he could have access to definitive care.

BY MS. FAN:

Q. And to be clear, the kind of cardiovascular complications that Mr. Snookal would experience with an aortic root would be a rupture, or dissection; is that correct?

A. Yes.

Q. And the third complication you mentioned relating to a dilated aortic root was death?

A. Yes.

Q. So, of course, if a death had occurred, no interventions would be possible.

MS. FLECHSIG: Incomplete hypothetical.

THE WITNESS: Yes.

BY MS. FAN:

Q. Based on your knowledge of the medical

facilities in Escravos, would they be able to support Mr. Snookal if he suffered a cardiological event?

MS. FLECHSIG: Objection. Incomplete hypothetical. Vague and ambiguous as to cardiac event.

THE WITNESS: No.

BY MS. FAN:

Q. And to clarify, if Mr. Snookal suffered a rupture in -- strike that.

If Mr. Snookal experienced a rupture relating to his dilated aortic root in Escravos, based on your knowledge of the medical facilities available, would they be able to support Mr. Snookal in the event of a rupture?

MS. FLECHSIG: Objection. Vague and ambiguous as to the meaning of support.

THE WITNESS: No.

BY MS. FAN:

Q. Based on your knowledge of the medical facilities in Escravos, would they be able to support Mr. Snookal if he suffered a dissection relating to his dilated aortic root?

MS. FLECHSIG: Objection. Vague and ambiguous as to the meaning of support. Incomplete hypothetical.

THE WITNESS: No.

REPORTER'S CERTIFICATE

I, Lauren Ramseyer, Certified Shorthand Reporter licensed in the State of California, License No. 14004, hereby certify that the deponent was by me first duly sworn and the foregoing testimony was reported by me and was thereafter transcribed with Computer-Aided Transcription; that the foregoing is a full, complete, and true record of said proceedings.

I further certify that I am not of counsel or attorney for either or any of the parties in the foregoing proceeding and caption named or in any way interested in the outcome of the cause in said caption.

The dismantling, unsealing, or unbinding of the original transcript will render the reporter's certificate null and void.

In witness whereof, I have hereunto set my hand this day: November 19, 2024.

Lauren Ramseyer, CSR No. 14004

EXHIBIT C

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA - WESTERN DIVISION

MARK SNOOKAL, an individual, Plaintiff, v. CHEVRON USA, INC., a California Corporation, and DOES 1 through 10, inclusive, Defendants.	)	NO. 2:23-cv-6302-HDV-AJR

Videotaped deposition of ALEXANDER R. MARMUREANU, M.D., Witness, taken remotely on behalf of Defendants commencing at 2:04 p.m. on Wednesday, January 29, 2025, before John M. Taxter, Certified Shorthand Reporter No. 3579 in and for the State of California, a Registered Professional Reporter.

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VIDEOGRAPHER:

JODY PADILLA

A It's exactly what it says. But I will add today that, even if his work was not desk-based and involved a lot of physical activities and would have been physically demanding, I still didn't find any evidence to suggest that his condition would affect his job performance or pose any immediate risk. 14:35:07 14:35:09 14:35:13 14:35:17 14:35:19 14:35:24 14:35:26

Q And when you say a "desk job," did you get that from the job description? 14:35:28 14:35:30

A I have no idea. I don't remember. 14:35:32

Q Do you remember if that's something that the -- your -- the attorneys told you? 14:35:33 14:35:36

A I don't remember. 14:35:36

Q And I'm going to highlight another sentence here -- whoops -- sorry -- and it's this first sentence of the third paragraph on page 6. It says: 14:35:44 14:35:46 14:35:51 14:35:55

"In conclusion, the evidence overwhelmingly supports that Mr. Snookal's aneurysm does not pose any clinically significant risk...given" -- "particularly given his travel to Nigeria every other month." 14:35:55 14:35:57 14:35:59 14:36:02 14:36:03 14:36:08 14:36:11

So my question is when you say 14:36:12

"clinically significant risk," what do you mean by that? 14:36:13 14:36:17

A That's exactly what I say, "clinically significant risk." I could add today, now that you asked me, in my opinion, the evidence based on my training, practice, education, experience, and the nine articles I provided, it shows that the incidence of aortic dissection rupture in someone with his comorbidities and the size of the aortic aneurysm, ascending aorta, would be probably around .1 percent. So this is ten times less than one percent. 14:36:17 14:36:20 14:36:22 14:36:28 14:36:30 14:36:33 14:36:38 14:36:43 14:36:46 14:36:49

So as I sit here today, it is my opinion that those issues, the so-called annulus which it is minimally large, probably the upper limit of normal, does not pose any risk. And I did say here "particularly given his travel to Nigeria every other month." The reality of, I could add, given his travel to anywhere in the world every week, it's just there is no risk. So I don't want you to link it to the -- to the Nigeria. I don't believe that -- clearly, he's got some disability. Clearly, he's got the aortic annulus, a little bit enlarged. And I'm going to say four -- at 4.0 is normal. 4.2. The way you look at a CAT scan, 14:36:50 14:36:54 14:36:58 14:37:02 14:37:05 14:37:09 14:37:14 14:37:17 14:37:20 14:37:25 14:37:28 14:37:31 14:37:34

was asked.

A I did answer. I said not that I remember --

Q Okay.

A -- and then I elaborated.

MS. KENNEDY: All right. Thank you. All right. I don't have any more questions. I don't know.

Dolores, Olivia, do you have any questions?

EXAMINATION

BY MS. LEAL:

Q Just one follow-up question. Doctor, Ms. Kennedy asked you if you had spoken with Mark Snookal, and I believe your answer was "no."

Is that correct?

A That's the best of my recollection. Do you -- refresh my recollection.

Q Right.

A I don't think I did, no.

Q Okay. So would your opinion have changed in any way, had you spoken or interviewed Mr. Snookal?

A Absolutely not. My opinions are based

on the data, the CT scan, the CT angio, and all the medical records. I can formulate the plan. I don't need to look at the patient or evaluate the patient. It's all the based on the guidelines that I actually provided to you yesterday. It might be today. 15:18:13 15:18:19 15:18:21 15:18:24 15:18:26 15:18:29

Q Okay. Thank you. 15:18:30

A Thank you. 15:18:31

MS. LEAL: Thank you, Doctor. 15:18:31

I don't have anything else, Tracey. 15:18:32

15:18:32

FURTHER EXAMINATION 15:18:32

BY MS. KENNEDY: 15:18:32

Q Just one follow-up. 15:18:33

A Sure. 15:18:34

Q Doctor, you said the guidelines you provided yesterday. 15:18:35 15:18:36

Are you referring to the Exhibit 3 I just showed you? 15:18:37 15:18:39

A That -- that's correct. Actually, that I sent today. 15:18:40 15:18:42

Q Okay. 15:18:42

A It's the main part of that. I wrote it. And, again, if you feel that was provided to you and being late and I understand and I agree, and I 15:18:45 15:18:46 15:18:48

STATE OF CALIFORNIA)
) SS.
COUNTY OF VENTURA)

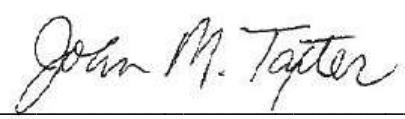
I, John M. Taxter, a California Certified Shorthand Reporter, Certificate No. 3579, a Registered Professional Reporter, do hereby certify: That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the deponent was put under oath by me; that the testimony of the deponent and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed; and that the foregoing is a true and correct transcript of my shorthand notes so taken.

I further certify that I am neither counsel for nor related to any party to said action.

The dismantling, unsealing, or unbinding of the original transcript will render the Reporter's Certificate null and void.

Pursuant to Federal Rule 30(e), transcript review was requested.

Dated February 11, 2025.



JOHN M. TAXTER
California Certified Shorthand Reporter No. 3579, RPR

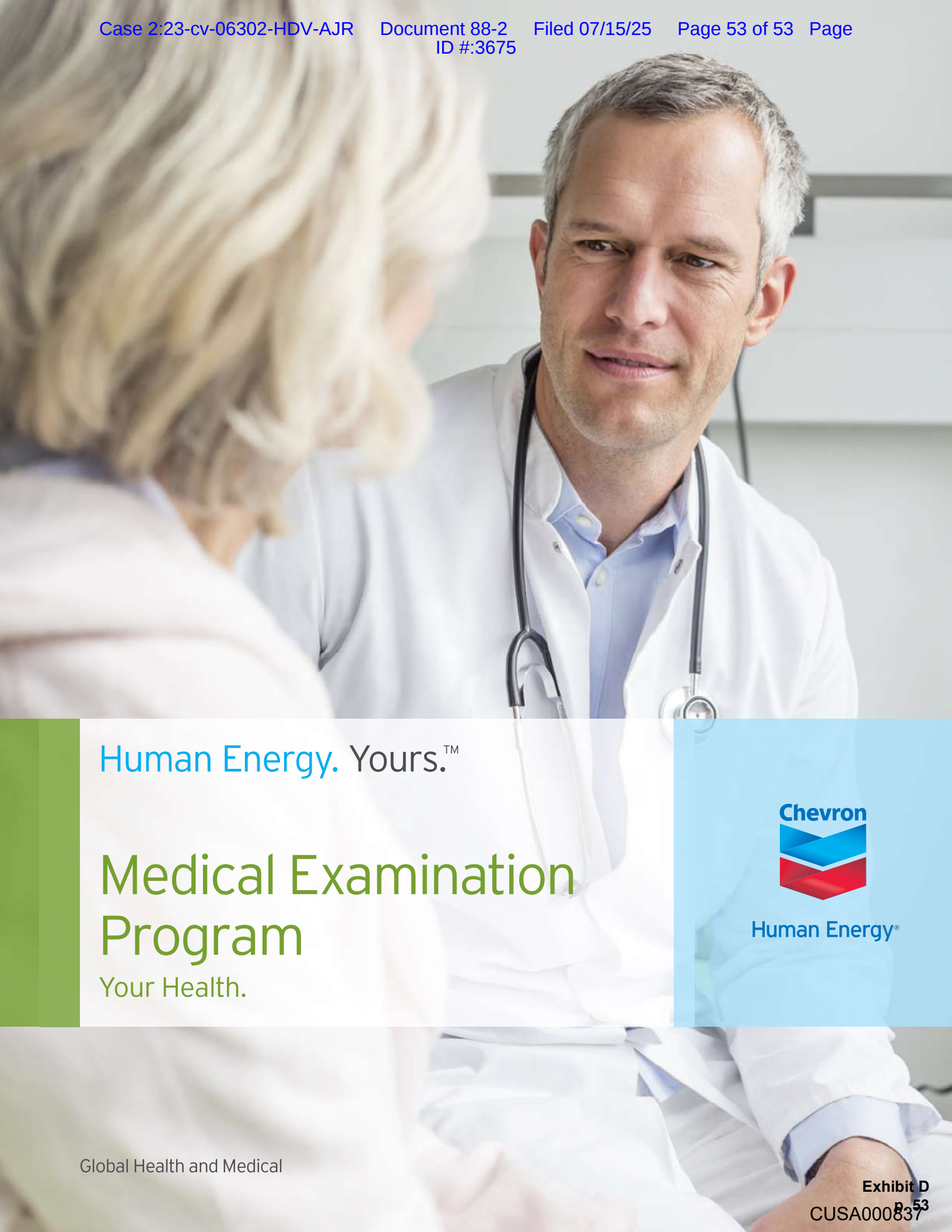
I, John M. Taxter, Certified Shorthand Reporter, CSR No. 3579, hereby certify:

The foregoing is a true and correct copy of the original transcript of the proceedings taken by me as thereon stated.

Dated: February 13, 2025

John Taxter, CSR No. 3579

EXHIBIT D



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